Experts' Roundtable

A resident's deteriorating medical condition often triggers transfer to emergency care, but how often do external factors—such as the unavailability of staff physicians or care decisions erring on the side of caution—result in overuse of emergency resources, unnecessary stress for residents and families, greater chance of transitional-care miscommunication, and increased medical costs?

C. Gresham Bayne, MD
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The trip to the emergency department (ED) is fraught with problems: expense, time, loss of care continuity, stress to the frail elderly, not to mention the inevitable overtreatment we are forced to perform (I am an emergency physician). A recent study shows that 53% of ED patients don't even need urgent care; as many as 85% don't need immediate physician attention. The problem is the predilection the frail elderly have for "soft" presentations of serious emergencies; ie, sudden weakness can be a stroke or heart attack in a demented patient. No set of algorithms exists that can meet the need for safe telephone consultation to discriminate these patients from nonurgent conditions. Indeed, after 300,000 house calls, our medical group has found that portable lab testing at the bedside and occasionally an ECG are required to make the decision together with a history and physical performed by the direct physician or mid-level professional.

Assisted living (AL) facilities need to find a medical director, and the good news is many doctors have found this setting to be a pleasant and worthwhile practice site. Although Medicare cut the physician's part of payment for home and rest home visits by 10% in January, this cut may even be driving house call physicians away from the home and into the facility setting to save on travel time.

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To help prevent inappropriate transfers to acute care, it is essential that nurses be proficient in their geriatric assessment skills and abilities to transmit the essential information a clinician needs to make an informed decision regarding transfer to the ED or treatment in the AL setting. In addition, nurses need to be aware of and transmit information about any documented patient preferences for care. All appropriate assessment information needs to be available when the call is placed to the clinician. In my experience, the American Medical Directors Association's (AMDA's) Physician Notification Guidelines are a good place to start to ensure that this process occurs in all care settings.

The flip side of preventing inappropriate transfers is ensuring that necessary transfers and care occur. It is essential that nonprofessional nursing staff be able to identify and report acute changes in AL resident conditions. For example, up to 67% of AL residents may have dementia. Delirium (acute confusional state), a medical emergency, occurs more frequently in those who are demented, yet it frequently goes unrecognized by both nursing staff and ED physicians; the mortality rate is 15% to 30% in untreated patients. By recognizing this change in mental status and transmitting this information to the resident's clinician and to the ED, appropriate care can be ensured.

Linda C. Drummond, MSM
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The response to this important question depends on the size of the AL community, the resources available and whether it is part of a continuum of care—ie, nursing facility or continuing-care retirement community (CCRC). Our company has found that when the AL community is part of a larger system, there are usually better care management practices in place to respond to an emergency situation. In a small community, rescue is often called and the resident is brought to the ED for evaluation. In some cases, the resident is admitted to the hospital and in others returned to the AL community. One problem we have observed is the lack of awareness on the part of AL evening staff regarding do not resuscitate (DNR) status, which may lead to medical intervention that goes against the wishes of the resident and family.

If we are committed to assisting residents "age in place," I feel we need to not just put good care management practices in place to respond to emergencies but to look at the bigger picture of embracing "whole-person wellness,"[1] ultimately creating a culture of wellness in an AL community. The whole person wellness philosophy is based on the concepts of prevention and active aging and includes emotional, intellectual, social, physical, spiritual, vocational, and personal wellness.

As part of the physical wellness component, a statistically valid test, called the Senior Fitness Test (SFT),[2]

can be used to measure the physical attributes (ie, strength, endurance, flexibility, agility, and balance) needed to perform everyday activities in later life. A staff member, preferably someone who is involved in physical activities, can be trained to use this software, ideally at the time of move-in to establish a baseline. The test results can then be used to assist in developing an individualized wellness program for the resident, which includes all of the dimensions of wellness mentioned previously. Developing a wellness model or culture that is based on health vs. disease and strength vs. deficit and is oriented toward results assists in minimizing unnecessary transfers to hospital EDs.

Anne Ellett, NP-C, MSN
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Silverado Senior Living

This is one of the clinical outcomes that Silverado looks at every month—how many residents get transferred out to acute/ED care and what are their diagnoses? Because Silverado has licensed nurses 24/7 on site, our transfer rate is quite low. In 2006, only 4.4% of our population had to be transferred out for emergency services. Most of our emergency transfers are to evaluate a possible fracture after a fall. Because we recognize how traumatic an emergency transfer is for our residents, we work very hard to have systems in place to avoid unnecessary emergency trips.

We have found that there are several factors influencing whether a resident is transferred out:

1. *The education level of the nurses*. We provide training on assessment and when to communicate with the physicians. We focus on early assessment if a resident is starting to get ill so we can catch infections and other conditions early and get oral treatment started. We also train caregivers about what types of resident changes they need to bring to the nurses' attention.
2. *Good communication*. All of our residents have dementia, so we over-communicate with families if a resident has a change of condition. We let the families know the condition of their loved one and assessments and treatments ordered by physicians; and we give them periodic updates. We try to make families comfortable knowing that their loved one is being cared for and monitored on an on-going basis.
3. *Knowledge of each residents' advance directives and desire for hospitalization*. Nursing staff are very aware of residents' advance directives, and we confirm and update this status in each care plan meeting. We work with families on clarifying what level of care they expect if their loved one becomes ill.
4. *Accessibility of the physicians*. Most of our physicians are readily available, either to stop by to see a resident or by phone for consultation. This availability helps tremendously to get treatments started early. We also use mobile x-ray and lab services that come to our communities, helping to avoid unnecessary ED trips.

Steve Friend, CPCU
Vice President of Claims
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Visits to the ED generally "raise the antenna" of a resident's family. Significant questioning of the care ensues, addressing whether the facility has faltered relative to the care provided. This questioning can be the predecessor to a claim or lawsuit alleging improper care.

In addition to cautious care decisions or unavailability of staff physicians, it is the deteriorating medical condition that goes unnoticed or is not communicated that spurs "overuse" of the ED. Several care management approaches can be used to help alleviate the problem:

Frequent Assessment

Frequent, objective assessment needs to take place long before a resident's condition results in the need to visit the ED. It is important that the nursing staff assess and communicate, from shift to shift, a resident's condition, especially when a decline is noticed. There are usually signs that an "event" is going to take place. Frequent assessment and communication should result in intervention that can help prevent an event.

Educating Family Members

It is difficult for family members to come to grips with the fact that their loved one may need skilled care. This can result in longer stays in AL and can contribute to an "event." It is important to educate family members about the care that can be provided in AL versus skilled nursing facilities (SNFs). Frank discussion early on, along with education about the difference between skilled nursing and AL care, can make the transition more bearable when the time comes.

Proper Planning

Bed shortages in SNFs often result in longer AL stays. AL facilities adapt by providing more "skilled-care services," creating additional risk. Again, it takes the occurrence of some event to prompt an assessment and make the change from AL to a SNF. Proper planning of bed availability in SNFs and necessary equipment (for skilled-care services) in AL can help alleviate the problem.

Robert Fusco, RPh, CCP, FASCP
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The problem of care management approaches in AL is a complex issue. The first thing a caregiver in an AL facility must do is call 911 if they detect any possible problems with a resident. After all, the nurse is not always available in the facility at the time the caregiver discovers a problem. The policy in most AL facilities is to call 911 and then the nurse.

A bigger problem is that most residents do not inform the staff or nurse that they have a problem. The resident does not want to bother the caregivers because they are too busy taking care of others. So instead of informing the caregivers, the resident may ignore it until it is too late and requires emergency care. Another scenario is that the resident waits until the family comes to mention a problem. The family may or may not advise the nursing staff of the problem. Oftentimes, the family tries to solve the problem by taking the resident to a physician (delaying the time needed to diagnosis and treat the problem immediately). This scenario never involves the staff at the facility and thus creates an acute situation for the resident that is out of the hands of the facility.

The only advice I can give to our readers is to educate both the family members and the new residents coming into your facility to be aware of this lack of communication, so that perhaps future events will be caught before they become emergencies.

Daniel Haimowitz, MD, FACP, CMD
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External factors frequently result in AL residents being sent to the ED without physician input. On weekends and evenings, RNs and LPNs may not be available, so physicians are unable to get trustworthy assessments and opinions. At a larger facility where I see residents, there are even weekdays when no nursing staff are present in the building!

Some AL facilities have policies in which any resident who falls—nearly every incident even without injury—is sent to the hospital. This is a misguided attempt to lower liability and results in increased costs and potential increased harm to residents.

One approach I have insisted on, with varying degrees of success, is having the AL staff call me prior to sending any resident to the emergency setting. I may know the patient's history or the family's expectations better than the staff do, and as part of the healthcare team may be able to prevent inappropriate ED transfers (for instance, for a hospice patient). An involved physician or medical director may be able to discuss with the facility administration or corporation about changing policies such as mandatory fall transfer.

Adopting preventive strategies commonly used by managed care organizations, like those for closely monitoring patients with congestive heart failure or fall prevention measures such as osteoporosis screening and treatment, exercise, and hip protectors, should lower the number of acute care episodes that require ED visits.

Unfortunately, convincing facilities to hire the increased staff needed to care for those residents with higher acuity who are now entering AL is a nut I haven't been able to crack! Research to prove financial benefits and improve quality of life is needed. Also helpful would be some way to prove that liability risk isn't lowered by unnecessary hospital transfers.

Nancy L. Losben, RPh, CCP, FASCP, CG
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Caregivers in AL residences should receive training that allows them to make an informed decision on when to send a resident to the emergency department (ED) or when it is appropriate to call the resident's family practice physician for guidance.

Professional associations, including the American College of Emergency Physicians and the American Academy of Emergency Medicine, offer guidelines on when a patient should be seen in an emergency care unit. Conditions that warrant emergency care are chest pain; pain in the left arm, neck, or jaw; shortness of breath; sudden, severe headache; weakness on one side of the body or face; arm or leg weakness; slurred speech; bleeding that will not stop; and blood in vomit or stool.

Staff members should place a call to the resident's doctor when the resident has a fever, abdominal pain with vomiting and diarrhea with or without fever, skin rash associated with a medication, gradual headache with or without neck stiffness, and productive cough.

Providing staff of AL facilities with guidance to prioritize health conditions best managed in an ED and those that can wait until medical advice is given promotes appropriate and rational healthcare utilization.

Dr. John Heath
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Roberto Muniz
President
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AL residents enjoy a greater degree of independence and autonomy than residents in skilled nursing settings, although they often share a surprisingly similar level of medical complexity and health risks. The higher level of preserved functional skills and cognitive abilities among AL residents also comes with the responsibility to exercise their good judgment about how and when they need to access health professional services like doctor visits and nursing care services to help them monitor and manage their health conditions. In a true acute healthcare crisis, the use of EDs can be life-saving. But the judgment about the severity of a particular change in health condition is often difficult for individuals to make alone. At the same time, we recognize the importance of respecting autonomy and preserving decision-making abilities of our seniors even when their decisions aren't what we would advise. The challenge then is how best to assist AL residents in a manner acceptable to them about how best to respond to a change in health status: does a particular change in symptoms require calling 911, placing a call to an on-call physician or nurse, planning a visit to an early morning clinic the next day, or reaching for a simple over-the-counter remedy and reassurance? Having an available advocate—not necessarily a medical professional—who knows the individual senior and has earned his or her trust is best, especially if that individual also has been granted healthcare proxy status.

Melody Moore, RN, BSN
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The overuse of emergency resources is a definite problem in today's healthcare system. Being able to prevent emergencies is not always possible; however, AL facilities should be implementing systems to allow residents to receive medical management before an acute episode occurs.

At Lakeview Assisted Living, we are fortunate enough to have LPNs around the clock and 2 RNs on call at all times. Nursing staff must have assessment skills and the confidence to notify physicians of even subtle changes in a resident's condition if they feel it is necessary. Communication between resident assistants (the staff most intimate with the resident) and nursing is also essential. Nursing assistants often recognize changes in their residents before anyone else does. The assistant's opinion and reporting should never be undervalued. Nurses should always appreciate and follow up on any report from an assistant and complete a full assessment if necessary.

The nurses at Lakeview often fax physicians with changes in condition or questions concerning a resident's medical condition. These questions can be as simple as the need for advice for treating a simple rash (the nurse describes the rash, symptoms, and resident complaints) or how to best control dependent edema (before it becomes a symptom of congestive heart failure). The physician is notified by phone if an immediate response is required. Often a fax is sent and responded to the same day, thereby eliminating the need for further evaluation by the physician. This type of reporting from resident assistant to nurse to physician in the AL facility allows the resident to have quality medical care in a nonmedical environment.

Staff who know their residents and feel confident in their assessment skills can certainly decrease the need for an emergency hospitalization. Communication with the primary physician is essential for reducing the need for emergency evaluation. Small problems addressed before they become large medical issues not only save lives, but also ensure quality of life and decrease medical cost for all of us.

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As "acuity creep" continues to occur in AL environments, it becomes imperative that providers implement models of care that support chronic disease management. Such models include thorough assessment of the resident at the time of move-in to identify risks for falls, risks for elopement, skin breakdown, weight loss concerns, and so on. In addition to thorough assessment, timely intervention in response to risks is also paramount.

One model that supports care management in AL is the "house calls" model. These services typically include collaborating physicians and nurse practitioners (or physician assistants) who see residents in their AL apartments on a regular basis. The average AL resident has 3 to 5 chronic disease processes and takes 9 to 11 medications on a regular basis; consistent management of the medication regimen and detection and treatment of subtle changes in chronic conditions can minimize the need for most of the "emergency" transfers. If these services are available on-call, as many are, staff can reach a person with access to the resident's treatment record on a 24-hour basis. The physicians or NPs can

then direct staff about how to intervene, or the physician or NP can schedule a visit with the resident to address the resident's change of condition.

The house calls model represents a cost-effective means of providing resident-centered care in a familiar environment, eliminating unnecessary stress for residents and families and enhancing the probability for increased length of stay with a better quality of life—with fewer transfers out of the building. Coupled with home health or hospice services, as indicated, the house calls model is ideal for supportive care in the AL environment.

Barbara Resnick, CRNP, PhD
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Certainly a transfer to the ED is the default when AL staff are concerned about a resident and feel that the care required is beyond the scope of the available staff or resources within the site. Unfortunately, prevention of all acute episodes is impossible. However, assessment of the situation to determine an appropriate need for transfer is well within the realm of nursing care. Comprehensive and thoughtful assessment can help to identify acute problems early and initiate treatment before an emergency transfer is needed. A good assessment can also help to establish the need for further testing. An example is a post-fall evaluation that identifies specific areas of pain. This information can be relayed to the primary care provider and an x-ray obtained, providing data on which to make a decision about further treatment.

Assessment skills can be taught to all staff using a team approach. A local medical director within a long-term care (LTC) facility, a physician who sees residents living in the facility, or a nurse practitioner who practices within the site could be invited to perform walking rounds with the delegating nurse and nursing assistants. Protocols for the assessment of commonly occurring events such as falls, fever of sudden onset, change in behavior or mood, or dizziness can be established to help guide the nursing staff in what information to gather and report to the appropriate primary care provider when the event occurs.

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From a pharmacy perspective, there is room to improve the overall use of medications in the AL environment by utilizing the services of a consultant pharmacist (CPh). Because there is no federal guidance requiring a Medication Regimen Review (MRR) in AL facilities, CPh resources are inconsistently used. Many hospitalizations of elderly residents result from medication-related problems; therefore, prevention of these problems could conceivably reduce the frequency of ED visits. Even in states in which MRRs are not required in the AL setting (and most states have no requirements), it would be wise to have a pharmacist with a strong geriatric background as a resource. This pharmacist could be employed by the main pharmacy provider or an independent consultant. Ensuring that AL residents, many of whom qualify for Medication Therapy Management (MTM) under the new Medicare Drug Benefit, avail themselves of MTM services is another step towards prevention of unnecessary ED visits. Some Medicare Part D plans pay pharmacists to perform these services, which can be done at the AL facility. Prevention of medication-related problems is always a good component of a care management program.

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Almost everyone seems to blame a resident's deterioration on a lack of a physician visit or insufficient staffing. In the AL setting, physicians are not expected to be present to the same extent they are in a skilled nursing facility (SNF). However, families often assume that physicians will be notified if their loved one has what is commonly termed a "change of condition." Is this a realistic expectation? One would hope so, but one must also ask, what is the level of staff training within the AL facility? Does the staff know how to recognize when a resident has subtle signs of changes, such as in meal intake, gait, sleep pattern, or socialization, which together or individually can mean that something "bigger" is going on. In a SNF facility, such changes would trigger a call to the practitioner. Even a feeling that "something's not quite right with Mrs. Jones" may precipitate a call. Many practitioners in SNFs have come to trust and act on these feelings. The lack of AL staff training was discussed at the AMDA-led Assisted Living consensus conference last October. One conclusion was that hands-on nonlicensed staff in these settings must be trained to notice changes in AL residents so that they know to notify practitioners. Without this training, it isn't practical to start looking at physician availability or insufficient staffing. ALC

References

1. The definition of whole-person wellness is taken from the body of work of Janice Montague, vice president, Wellness Initiatives, Lakeville Village, Lenexa, KS.

2. Senior Fitness Test (SFT) software, developed by Roberta E. Rickli and C. Jessie Jones, is distributed by Human Kinetics at www.humankinetics.com.